No. 06-923

In the Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY), ET AL., PETITIONERS

v.

WANDA GLENN

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTIONS PRESENTED

1. Whether an administrator that both evaluates and pays claims under a plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 *et seq.*, is operating under a conflict of interest that must be weighed on judicial review of a benefit determination.

2. Whether an ERISA plan administrator must consider in its written benefit determination a decision of a Social Security Administration administrative law judge granting disability benefits.

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This brief is submitted in response to the order of this Court inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition should be granted on the first question presented, and the parties should be directed to address a related question. See pp. 11-13, 22, *infra*. The petition should be denied on the second question presented.

STATEMENT

1. The Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 *et seq.*, was enacted to "protect * * * the interests of participants in employee benefit plans and their beneficiaries * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries of [those] plans, and by providing for appro-

priate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1001(b). As part of ERISA's comprehensive enforcement scheme, Section 502(a)(1)(B) authorizes a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan." 29 U.S.C. 1132(a)(1)(B).

In *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), this Court considered the appropriate standard of review in an action to recover benefits under an ERISA plan. *Id.* at 108. Noting that Congress did not specify a standard, the Court turned to the purposes of ERISA and its basis in trust law to determine the appropriate standard. *Id.* at 108-115. It concluded "that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case abuse-of-discretion review applies. *Id.* at 115. The Court noted, however, that more searching review is necessary in the case of a conflicted decisionmaker: "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Ibid.* (quoting Restatement (Second) of Trusts § 187 cmt. d at 403 (1959) (Second Restatement)).

2. Respondent worked for Sears, Roebuck and Company (Sears) from 1986 until 2000, when she was diagnosed with a heart condition and took a medical leave of absence. Pet. App. 2a-3a. Respondent then applied for disability benefits under her Sears-sponsored ERISA plan, which was both administered and insured by petitioner MetLife. *Id.* at 2a-3a. MetLife approved respon-

dent's claim for short-term disability benefits. *Id.* at 3a. At MetLife's direction and with the help of counsel retained for her by MetLife, respondent then applied for and received Social Security disability benefits. *Ibid.*

After paying short-term benefits for the maximum term, MetLife notified respondent that she must demonstrate that she qualified for long-term disability benefits, which required her to establish her inability to perform "*any* gainful work" for which she was reasonably qualified. Pet. App. 3a-4a. Respondent submitted medical records from Dr. Rajendera Patel, her treating cardiologist, who ultimately concluded that respondent's heart condition made her unable to "return to any kind of even sedentary work." *Id.* at 4a-7a. MetLife had an independent physician and a vocational rehabilitation coordinator review respondent's file. *Id.* at 30a. It then concluded that the medical records did not support her claim of total disability and terminated her benefits. *Id.* at 7a. Respondent appealed, and MetLife affirmed its denial of disability benefits. *Id.* at 8a.

3. The district court upheld MetLife's denial of benefits. Pet. App. 27a-40a. The court applied an "arbitrary and capricious" standard of review because the plan "grant[ed] the administrator discretionary authority" to determine benefits. *Id.* at 32a-33a. It noted, however, that "an actual conflict of interest exists" because MetLife "both decides whether an employee is eligible for benefits and pays those benefits," and that conflict must be "weigh[ed]" "as a factor" in reviewing the benefits denial. *Id.* at 32a-34a.

The district court then reviewed the medical evidence and concluded that MetLife's decision was not arbitrary and capricious because there was "substantial evidence supporting MetLife's determination that [re-

spondent] was no longer disabled." Pet. App. 37a-40a. In so holding, the court recognized that the administrator had not considered the award of Social Security disability benefits, but the court rejected respondent's contention that the award substantiated her disability, finding that "the records before the ALJ and MetLife were materially different." *Id.* at 36a.

4. The court of appeals reversed and reinstated respondent's benefits. Pet. App. 1a-26a. Like the district court, it applied an "arbitrary and capricious" standard of review because the plan granted the administrator discretionary authority to determine benefits. *Id.* at 9a. The court held, however, that MetLife was operating under an "apparent conflict of interest" because it was "authorized both to decide whether an employee is eligible for benefits and to pay those benefits," and it concluded that the district court failed to give that conflict "appropriate consideration" in reviewing the benefit denial. *Id.* at 10a.

The court of appeals also determined that the district court gave "inadequate consideration" to MetLife's failure to address the award of Social Security disability benefits, particularly in light of the fact that MetLife "had encouraged and assisted [respondent] in obtaining Social Security disability benefits" and "benefitted financially from the government's determination that [respondent] was totally disabled." Pet. App. 10a, 14a-15a. Although that failure "d[id] not render the decision arbitrary *per se*," the court held, it was "a significant factor to be considered upon review." *Id.* at 15a.

After reviewing the medical evidence, the court of appeals held that MetLife's "inappropriately selective consideration of [respondent's] medical record," combined with its conflict of interest and its failure to ad-

dress the Social Security disability benefits award, led to a benefit denial that "can only be described as arbitrary and capricious." Pet. App. 25a.

DISCUSSION

Since *Firestone*, the courts of appeals have struggled with how to review a benefit determination by an ERISA plan administrator that is vested with discretionary authority to interpret plan terms or make benefit determinations and also must pay any claims that it finds to be valid. Clear circuit conflicts have developed on two questions. First, the courts of appeals disagree on whether an administrator that both makes claims determinations and pays benefits should be regarded as operating under a conflict of interest that must be taken into account on judicial review of its benefit determination. Second, the courts of appeals have divided on the closely related question of how to weigh such a conflict of interest, if one is deemed to exist, in reviewing a benefit determination. Both questions were raised throughout this case, both questions were addressed by the court of appeals below, and both questions are of substantial importance. Accordingly, the United States recommends that this Court grant review on the first question presented in the petition, and also direct the parties to address in their briefs the further question of how a court should weigh a conflict of interest in reviewing a dual-role administrator's discretionary benefit determination.

This Court's review is not warranted on the second question presented. The circuits agree that the weight to be given to a Social Security disability determination varies based on the facts of the case, and the Sixth Cir-

cuit reasonably took the award of Social Security benefits into account in the circumstances present here.

A. The Question Whether A Dual-Role Plan Administrator Has A Conflict Of Interest Warrants This Court's Review

1. The decision below conflicts with the decisions of several other courts of appeals on two intertwined and important questions

This Court explained in *Firestone* that, although ERISA benefit determinations generally should be reviewed *de novo*, abuse-of-discretion review applies if "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115. Under that standard of review, an administrator's exercise of judgment "will not be disturbed if reasonable." *Id.* at 111 (citing George G. Bogert & George T. Bogert, *The Law of Trusts and Trustees* § 559, at 169-171 (2d rev. ed. 1980)); see also Restatement (Third) of Trusts § 87 cmts. b and c at 243-244 (2007) (Third Restatement); Second Restatement § 187 cmt. e at 403 (court will not interfere unless trustee "acts beyond the bounds of a reasonable judgment"). The Court also indicated that more searching review is appropriate when the plan administrator labors under a conflict of interest. 489 U.S. at 115. Since *Firestone*, two questions have arisen with increasing frequency—and divided the courts of appeals—regarding how the courts are to apply that guidance in reviewing benefit determinations made by dual-role administrators that have discretionary authority to interpret plan terms or make benefit determinations.

a. First, there is a circuit split on the threshold question whether "the fact that a claim administrator of an ERISA plan also funds the plan benefits, without more, constitutes a 'conflict of interest' which must be weighed in a judicial review of the administrator's benefit determination." Pet. i. The Sixth Circuit in this case held that it does. Pet. App. 10a. The Sixth Circuit explained the basis for that approach in a prior decision, reasoning that a plan administrator that both funds and administers the plan has a financial incentive to deny benefits because it "incurs a direct expense as a result of the allowance of benefits," and it "benefits directly from the denial or discontinuation of benefits." *Killian* v. *Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 521 (1998).

The Third, Fourth, Fifth, Ninth, Tenth, and Eleventh Circuits have agreed that a plan administrator that also pays plan benefits operates under a conflict of interest that must be taken into account on judicial review of a benefit determination. See, *e.g.*, *Post* v. *Hartford Ins. Co.*, 501 F.3d 154, 161-164 (3d Cir. 2007)[1]; *Carolina Care Plan Inc.* v. *McKenzie*, 467 F.3d 383, 386-387 (4th Cir. 2006), cert. dismissed, Nos. 06-1182 & 06-1436 (July 30, 2007); *Vega* v. *National Life Ins. Servs., Inc.*, 188 F.3d 287, 295-296 (5th Cir. 1999) (en banc); *Abatie* v. *Alta Health & Life Ins. Co.*, 458 F.3d 955, 965-966 (9th Cir. 2006) (en banc); *Fought* v. *UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1003 (10th Cir. 2004), cert. denied, 544 U.S. 1026 (2005); *Brown* v. *Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561, 1566-1567 (11th Cir. 1990), cert. denied, 498 U.S. 1040 (1991).

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[1] The Third Circuit has suggested, however, that there is no conflict of interest when an employer "both funds and administers the plan, but pays benefits out of a fully funded and segregated ERISA trust fund rather than its operating budget." *Post*, 501 F.3d at 164 n.6.

The First and Seventh Circuits have come to the contrary conclusion, holding that the mere fact that a plan administrator also pays claims does not present a conflict of interest that must be taken into account on review of a discretionary benefit determination. See, *e.g.*, *Wright* v. *R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005); *Perlman* v. *Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999). Those courts have reasoned that although there is a *potential* conflict of interest in such circumstances, there is no need to adjust the level of scrutiny because market forces will counterbalance that potential. See, *e.g.*, *Perlman*, 195 F.3d at 981 (explaining that "the award in any one case will have only a trivial effect on [the administrator's] operating results," and plan administrators "want to maintain a reputation for fair dealing with" plan beneficiaries).

The Second Circuit appears to take the same view, holding that the mere fact of a plan administrator's dual roles does not "trigger stricter review" unless the plaintiff shows that "the administrator was *in fact* influenced by the conflict of interest." *Pulvers* v. *First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2000) (quoting *Sullivan* v. *LTV Aerospace & Def. Co.*, 82 F.3d 1251, 1255-1256 (2d Cir. 1996)). The Eighth Circuit's approach is similar, requiring, as a condition for heightened review, "material, probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to her." *Woo* v. *Deluxe Corp.*, 144 F.3d 1157, 1160-1161 & n.2 (1998). The decision below, which follows the majority approach, thus squarely conflicts with decisions of the First and Seventh Circuits and appears to be in significant tension

with decisions of the Second and Eighth Circuits. In all events, the circuits are clearly in disarray on the issue.

b. The courts of appeals also have divided on the closely related question of *how* a conflict of interest should be weighed on review of a plan administrator's discretionary benefit denial. They have adopted essentially three approaches: abuse-of-discretion review on a "sliding scale," *de novo* review, and burden-shifting.

The first approach, followed by the great majority of courts of appeals and utilized in the decision below, applies abuse-of-discretion review on something of a "sliding scale," whereby the plan administrator's decision is reviewed for reasonableness, and the particular degree of deference afforded depends on the seriousness of the conflict. The Third, Fourth, Fifth, Sixth, and Ninth Circuits utilize variations of this approach. See, *e.g.*, *Pinto* v. *Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000); *Doe* v. *Group Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (4th Cir. 1993); *Vega*, 188 F.3d at 297; *Borda* v. *Hardy, Lewis, Pollard & Page, P.C.*, 138 F.3d 1062, 1065-1069 (6th Cir. 1998) (applying abuse-of-discretion review that is "shaped by the circumstances of the inherent conflict of interest" but not calling it a "sliding scale" (internal quotation marks omitted)); *Abatie*, 458 F.3d at 967 (rejecting the "sliding scale" metaphor but adopting an approach that "is substantially similar to" the sliding-scale approach). In addition, although they do not view an administrator's dual roles alone as a conflict of interest, in circumstances where they do identify a conflict of interest, the First, Seventh, and Eighth Circuits increase the degree of scrutiny of a benefit denial using essentially the sliding-scale approach. See, *e.g.*, *Wright*, 402 F.3d at 74-75; *Mers* v. *Marriott Int'l Group Accidental Death & Dis-*

memberment Plan, 144 F.3d 1014, 1020-1021 & n.1 (7th Cir.), cert. denied, 525 U.S. 947 (1998); *Woo*, 144 F.3d at 1162.[2]

The Second Circuit follows an entirely different approach. Although it does not engage in heightened scrutiny based on an administrator's dual roles alone, when a claimant provides evidence that a potential conflict of interest exists and "'the administrator was *in fact* influenced by the conflict of interest,'" the court utilizes *de novo* review. *Pulvers*, 210 F.3d at 92 (quoting *Sullivan*, 82 F.3d at 1255-1256).

Finally, both the Tenth and Eleventh Circuits utilize burden-shifting approaches. In the face of a conflict of interest, the Tenth Circuit shifts the burden of proof to the plan administrator to establish "the reasonableness of its decision pursuant to [the] court's traditional arbitrary and capricious standard." *Fought*, 379 F.3d at 1006. Under that approach, the "administrator must demonstrate that its interpretation of the terms of the plan is reasonable and that its application of those terms to the claimant is supported by substantial evidence." *Ibid.* Under the Eleventh Circuit's approach, a reviewing court first determines, *de novo*, whether or not the denial of benefits was "wrong." *Brown*, 898 F.2d at 1566. If the benefit denial was correct, the administrator's decision is affirmed; if it was wrong, "the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." *Ibid.* If the administrator meets that burden, abuse-of-discretion review applies.

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[2] The Eighth Circuit applies a *de novo* standard in "egregious circumstances," but otherwise applies abuse-of-discretion review that is adjusted to account for the seriousness of the conflict. See *Woo*, 144 F.3d at 1161-1162.

See *HCA Health Servs. of Ga., Inc.* v. *Employers Health Ins. Co.*, 240 F.3d 982, 993-995 (11th Cir. 2001). If the administrator does not meet that burden, the court reverses the administrator's decision, having already determined on *de novo* review that it was erroneous. *Ibid.*

Because the Sixth Circuit in this case reviewed respondent's claim under abuse-of-discretion review, tempered by the particular factors warranting increased scrutiny here, Pet. App. 9a-10a, the decision below conflicts with decisions of the Second, Tenth, and Eleventh Circuits, thereby exacerbating an existing circuit split.

c. Certiorari is warranted on both questions that have divided the lower courts in order to provide guidance on when and how a reviewing court should account for a plan administrator's dual roles in both making benefit determinations and paying any benefits due. Since *Firestone*, a growing number of ERISA plans have granted dual-role administrators discretionary authority to determine benefits or interpret plan terms, and the entrenched disagreements in the courts of appeals have caused confusion and disuniformity, as some of the courts of appeals have acknowledged. See, *e.g.*, *Fought*, 379 F.3d at 1004 ("Our failure to articulate clearly the requirements of a less deferential arbitrary and capricious standard has left district courts in this circuit without direction and has encouraged litigation."); *Vega*, 188 F.3d at 296 ("Other Circuits have also struggled with the role a conflict of interest should play in determining whether an administrator has abused its discretion."). Indeed, one noted treatise has deemed "how trial courts are to consider the presence of a conflict of interest on the part of the administrator" "[p]erhaps the biggest question after *Firestone*." Jayne E. Zanglein & Susan J. Stabile, *ERISA Litigation* 507 (2d ed. 2005).

If this Court grants review, the Court should address not only *whether* a dual-role administrator has a conflict of interest, but also *how* a conflict of interest is to be weighed on judicial review of a benefit denial under a plan that grants the administrator discretionary authority to interpret plan terms or decide benefit claims. Those two issues are integrally related. It is, in fact, the latter question that has most "bedeviled the federal courts," *Pinto*, 214 F.3d at 378, and that question is fairly raised here. The latter question has salience in every circuit, because even the circuits that do not view a plan administrator's dual roles standing alone as a conflict of interest still must address how to adjust the standard of review in cases in which they identify a conflict of interest. See pp. 7-10, *supra*. Moreover, this Court itself has recognized the importance of the question of how reviewing courts should account for a conflict of interest in light of *Firestone*. See *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 384 n.15 (2002).

This case provides a suitable vehicle to address both questions, because the court below both found that MetLife operates under a conflict of interest and weighed that conflict in reviewing MetLife's benefit determination. See Pet. App. 9a-10a, 24a-26a. Moreover, because the decision below was correct (in the view of the United States) to identify a conflict of interest, see pp. 13-15, *infra*, the case presents an opportunity to resolve both issues. Respondent suggests that review is unwarranted because the court of appeals would have found that MetLife abused its discretion regardless of its conflict. Br. in Opp. 24. But the court of appeals did not hold that MetLife abused its discretion independent of the conflict; it instead found that the administrator's review of the medical evidence, its failure to address the Social Secu-

rity decision, and its conflict of interest, "*[t]aken together* * * * reflect a decision by MetLife that can only be described as arbitrary and capricious." Pet. App. 25a (emphasis added).

2. MetLife's dual roles in deciding benefit claims and paying benefits is a factor to be weighed in determining the reasonableness of the benefit denial

The Sixth Circuit correctly held that a plan administrator's dual roles as an administrator and insurer of benefits creates a conflict of interest that must be weighed as a factor in reviewing MetLife's benefit denial under *Firestone*.

a. "ERISA abounds with the language and terminology of trust law," *Firestone*, 489 U.S. at 110, and trust law principles counsel that the financial self-interest created when a plan administrator both decides claims and pays benefits should be taken into account by a court in reviewing a denial of benefits under the plan. When "discretion is conferred upon" a fiduciary "with respect to the exercise of a power," its exercise is subject to review for "an abuse * * * of his discretion," which calls for a court to determine whether the administrator's interpretation of the plan and findings concerning eligibility are reasonable. Second Restatement § 187 and cmt. d at 402-403; see p. 6, *supra*. One factor relevant under that test is "the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries." Second Restatement § 187 and cmt. d at 402-403.

In the case of a dual-role administrator, "every exercise of discretion impacts [the administrator] financially, filling or depleting its coffers." *McGraw* v. *Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1259 (10th Cir. 1998). That type of conflict generally warrants careful scrutiny

in the trust context, even in the absence of evidence that the plan administrator actually acted because of its financial self-interest. See, *e.g.*, Third Restatement § 37 cmt. f(1) at 137 (2003) (where a conflict of interests exists, "the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny"); *id.* § 50 cmt. b at 261 (beneficiary who is also trustee may have a permissible "conflict of interest, but his acts are to be carefully scrutinized for abuse"); Second Restatement § 107 cmt. f at 236 (remainderman of a trust who is also the trustee and thus must decide how much to pay to the beneficiary operates under a conflict of interest); 2A Austin W. Scott & William F. Fratcher, *The Law of Trusts* § 170.23A at 429 (4th ed. 1987) (bank with both a trust department and a commercial department has "the possibility of conflicts of interest" that should be "considered in determining whether the bank acted for the best interest of the beneficiaries"). Indeed, this Court appears to have recognized as much in *Firestone*, when it stated that a conflict of interest should be "weighed as a 'facto[r]'" in deciding whether a plan administrator has abused its discretion. 489 U.S. at 115 (quoting Second Restatement § 187 cmt. d at 403).

Further, the rule that a plan administrator's financial self-interest must be taken into account on review of benefit determinations is based on the common-sense notion that "[a] conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries." *Brown*, 898 F.2d at 1565; see also George G. Bogert & George T. Bogert, *The Law of Trusts and Trustees* § 543, at 227 (rev. 2d ed. 1993). And such a rule best comports with ERISA's broad purpose of "protect[ing] contractually defined benefits." *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 148 (1985).

Although ERISA permits plan funders to serve as claims administrators, see 29 U.S.C. 1102(c), 1108(c)(3), that authorization does not preclude an appropriately searching review of those administrators' decisions, for Congress left to the federal courts (guided by principles of trust law) the question of how they are to review a dual-role administrator's decisions. See *Firestone*, 489 U.S. 110-111.

b. This Court in *Firestone* also established the basic framework for *how* a conflict of interest should be taken into account on judicial review. ERISA generally permits employers, like settlors in trust law, to set up plans as they see fit, within the general parameters of the Act, see, *e.g.*, *Hughes Aircraft Co.* v. *Jacobson*, 525 U.S. 432, 444 (1999), and it permits them to grant discretion to plan administrators to interpret plan terms and determine claimants' eligibility for benefits, see *Firestone*, 489 U.S. at 115; 29 U.S.C. 1108(c)(3). ERISA also permits an employer to establish a welfare benefit plan "through the purchase of insurance." 29 U.S.C. 1002(1). A plan sponsor thus could reasonably choose to give discretionary authority for claims administration to an insurance company, notwithstanding its conflict of interest as the ultimate payor of benefits, in light of the cost of alternative arrangements, the insurer's expertise in administering and resolving claims, and the insurance company's past claims history. Where the sponsor has expressly chosen to give the insurer discretion to interpret plan terms or determine eligibility for benefits, review of those decisions applying the abuse-of-discretion standard—under which the decisions "will not be disturbed if reasonable," *Firestone*, 489 U.S. at 111—is the logical starting point because it best comports with the contractual and trust-law underpinnings of ERISA. See *id.* at 110-115.

At the same time, ERISA mandates that a fiduciary "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries," 29 U.S.C. 1104(a)(1), which incorporates the traditional duty of loyalty of a trustee, see Third Restatement § 79, at 127 (2007). Accordingly, the very principles of trust law that call for review of discretionary decisions under a general standard of reasonableness also counsel that a plan administrator's conflict of interest must be weighed as a factor under that standard, as this Court also recognized in *Firestone*. 489 U.S. at 115.

Because the Court in *Firestone* declined to rest its general rule of *de novo* review on the existence of an underlying conflict of interest, 489 U.S. at 115, *de novo* review should not be required where the plan vests discretionary authority in an administrator that also pays benefits. Rather, the existence and nature of a conflict of interest should be taken into account as *part of* traditional review for reasonableness, triggering more careful scrutiny to the degree that the circumstances warrant.

For example, the existence of a conflict of interest should cause a reviewing court to give added scrutiny when an administrator: (1) "provides inconsistent reasons for [the benefit] denial"; (2) "fails adequately to investigate a claim or ask the plaintiff for necessary evidence"; (3) "fails to credit a claimant's reliable evidence"; or (4) "has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record." *Abatie*, 458 F.3d at 968-969. In addition, concern would be raised if there is evidence suggesting that the administrator denied the claimant full and fair review of his claim, as guaranteed by statute and by the Department of Labor's claims regulations, see 29 U.S.C.

1133(2); 29 C.F.R. 2560.503-1(g), (h), and (j), although such a defect might constitute an independent ground for setting aside an administrator's decision. Also, an administrator, facing closer scrutiny, might find it advisable to demonstrate that it has taken measures to mitigate conflict concerns, through the use of truly independent medical examiners or by ensuring that its claims reviewers do not have incentives to deny claims. See *Abatie*, 458 F.3d at 969 & n.7.

This flexible case-by-case approach is most consistent with the Restatement of Trusts and pre-ERISA cases reviewing decisions by conflicted trustees who were acting under express grants of discretionary authority by the trust settlors. See, *e.g.*, *In re Peabody's Will*, 96 N.Y.S.2d 556, 561 (Sup. Ct.), aff'd, 98 N.Y.S.2d 614 (App. Div. 1950). Moreover, this approach best balances ERISA's requirements of fiduciary loyalty, 29 U.S.C. 1104(a)(1), and "full and fair" review of benefit claims, 29 U.S.C. 1133(2); see 29 C.F.R. 2560.503-1(g), (h), and (j), with the statutory authorization for fiduciaries to serve in dual roles, 29 U.S.C. 1108(c)(3), and for employers generally to set up plans as they see fit. The standard neither assumes that every fiduciary administrator with a conflict of interest resolves disputes in a biased manner, nor uncritically defers to the administrator's judgment as if the conflict did not exist. Review under a general standard of reasonableness simply requires that the reviewing court be as skeptical of the administrator's decision as the facts warrant. See *Woo*, 144 F.3d at 1161.

B. The Question Concerning A Plan Administrator's Consideration Of A Social Security Disability Award Does Not Warrant This Court's Review

Certiorari is not warranted to consider how a plan administrator should consider an award of disability benefits by the Social Security Administration (SSA) in its benefit decision. There is no split in legal authority on that question, and the decision below appropriately took that award into account in the circumstances of this case.

1. Contrary to petitioners' contention (Pet. 16), the decision below does not hold that an ERISA plan administrator "must" in all cases consider and refute a "bare" SSA disability determination. Pet. 16. Instead, the court concluded only that SSA's decision finding respondent disabled was a "relevant" factor that MetLife should have addressed in the particular circumstances of this case. Pet. App. 11a. And the decisions petitioners cite (Pet. 19) from the First and Second Circuits also do not hold that a plan administrator must *always* consider a bare SSA determination. See *Pari-Fasano* v. *ITT Hartford Life & Accident Ins. Co.*, 230 F.3d 415, 420 (1st Cir. 2000) (a "Social Security benefits decision *might be relevant* to an insurer's eligibility determination" (emphasis added)); *Paese* v. *Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 442 (2d Cir. 2006) (the district court "acted *well within its discretion*" in "*consider[ing]* the SSA's findings as some evidence of total disability" (emphases added)).

Although petitioners contend that several courts of appeals have rendered decisions in conflict with the decision below (Pet. 17-19), none of those decisions holds that "a bare decision by the Social Security Administration has *no* evidentiary value." Pet. 17. One case, *Conley* v.

Pitney Bowes, 176 F.3d 1044 (8th Cir. 1999), cert. denied, 528 U.S. 1136 (2000), simply stands for the unremarkable proposition that a plan is not *required* to "award benefits to any claimant who is receiving social security benefits." *Id.* at 1050. In another case, *Donato* v. *Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994), overruled on other grounds by *Diaz* v. *Prudential Ins. Co. of Am.*, 424 F.3d 635 (7th Cir. 2005), the Seventh Circuit declined to deem a failure to consider the "medical evidence contained in th[e] [Social Security] file" an abuse of discretion when that supporting evidence was not presented to the plan administrator, *id.* at 380; it did not come to any conclusion with respect to the SSA award itself. The remaining cited decisions represent fact-specific determinations that a plan administrator did not err in failing to give weight to an SSA award in a particular case.[3] Overall, the courts of appeals generally take a flexible approach to the question whether a plan administrator should have considered an SSA determination in a given case, as one would expect based on the fact-specific nature of that inquiry, and there is no legal disagreement that warrants this Court's review.

Indeed, the only other court to have considered the relevance of an SSA determination in circumstances substantially similar to those here took the same approach as the decision below. In *Ladd* v. *ITT Corp*, 148 F.3d 753 (7th Cir. 1998), as in this case, the plan administrator "encouraged and supported [the participant's] effort to

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[3] See *Madden* v. *ITT Long Term Disability Plan*, 914 F.2d 1279, 1285 (9th Cir. 1990) ("all medical evidence submitted to [the plan administrator]" supported a finding of no disability), cert. denied, 498 U.S. 1087 (1991); *Block* v. *Pitney Bowes, Inc.*, 952 F.2d 1450, 1455 (D.C. Cir. 1992) (SSA award was made four years after plan administrator's decision, on a materially different record).

demonstrate total disability to the Social Security Administration, going so far as to provide her with legal representation," then, contrary to SSA's determination and without even mentioning that determination, found that the participant was not disabled. *Id.* at 756. In the Seventh Circuit's view, the plan administrator's failure to consider the SSA determination, though not enough to "provide an independent basis" for reversal, "cast[] additional doubt on the adequacy of [the administrator's] evaluation" of the claim. *Ibid.* The Sixth Circuit cited and applied that approach in the decision below. See Pet. App. 12a-13a (citing *Ladd*, 148 F.3d at 755-756); see also *Darland* v. *Fortis Benefits Ins. Co.*, 317 F.3d 516, 530 (6th Cir. 2003) (applying *Ladd* in similar circumstances), overruled on other grounds by *Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822 (2003).[4] Thus, there is no disagreement as to the significance of an SSA determination in the narrow circumstances present here.

2. The Sixth Circuit reasonably took into account the Social Security disability award under the circumstances of this case. It did not hold that MetLife's failure to consider the award after helping respondent procure it rendered its ultimate decision "arbitrary *per se*"; instead, it found that because the award was based on a finding that respondent was totally disabled, MetLife should have considered the award when it evaluated respondent's condition. Pet. App. 14a-15a. The SSA determination

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[4] Petitioners' claim (Pet. 18) that the decision below conflicts with *Conley* v. *Pitney-Bowes*, 176 F.3d 1044 (8th Cir. 1999), is incorrect, because the court of appeals in that case considered materially different circumstances from this case. See *id.* at 1050 (declining to apply the *Ladd* principle because, among other things, the administrator "did not help [the participant] make his case to the Social Security Administration").

was plainly relevant because the Social Security standard was more stringent than the plan's definition of disability, *id.* at 13a & n.1, and respondent's condition remained essentially unchanged from the time of the SSA award to the time of MetLife's denial of benefits, *id.* at 3a-8a.

Moreover, the Sixth Circuit's approach is consistent with this Court's teaching that "[p]lan administrators * * * may not arbitrarily refuse to credit a claimant's reliable evidence." *Nord*, 538 U.S. at 834. And it is also consistent with the requirement that an ERISA plan provide for a "full and fair review" of a denial of a claim for benefits, 29 U.S.C. 1133(2), which "takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim," 29 C.F.R. 2560.503-1(h)(2)(iv); see 29 C.F.R. 2560.503-1(g)(1)(i) and (j)(1). Indeed, the plan document at issue in this case expressly provided that MetLife "will reevaluate *all the information*" in its files upon a request for review of a claim denial. Br. in Opp. 18 (quoting A.R. 23-24)).

There is, therefore, no reason to grant certiorari on the second question presented and dedicate substantial briefing to it as a stand-alone issue. Nonetheless, the briefing on the first two questions, and any application of the correct legal standard to this case, may involve discussion of the treatment of the SSA award as part of the reasonableness analysis. Thus, limiting the questions to the first question presented and the additional question suggested by the United States will focus the briefing on the questions that have divided the courts of appeals, without foreclosing discussion of the SSA award altogether.

CONCLUSION

The petition for a writ of certiorari should be granted on the first question presented, and the Court should also direct the parties to address the following related question: "If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?" Certiorari should be denied on the second question presented.

Respectfully submitted.

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DECEMBER 2007